		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040923

Facility Name: Lexington of Wheeling

Address: 730 W. Hintz Road (Number) Wheeling (City) 60090 (Zip Code)

County: Cook

Telephone Number: (847) 537-7474 **Fax #** (847) 537-7599

IDPA ID Number: 363885225001

Date of Initial License for Current Owners: 05/12/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	80,886	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	221	TOTALS	221	80,886	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,194	4,074	7,711	38,979	8
9	SNF/PED					9
10	ICF	15,586	2,018	1,086	18,690	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,780	6,092	8,797	57,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.30%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 221 and days of care provided 5,231

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	288,560	28,128	14,502	331,190		331,190		331,190			1
2	Food Purchase		271,324		271,324		271,324	(13,127)	258,197			2
3	Housekeeping	256,377	29,244		285,621		285,621	320	285,941			3
4	Laundry	61,894	20,608		82,502		82,502	(4,098)	78,404			4
5	Heat and Other Utilities			170,942	170,942		170,942	3,654	174,596			5
6	Maintenance	31,263		106,018	137,281		137,281	46,936	184,217			6
7	Other (specify):* **Allocated Benefits**							5,282	5,282			7
8	**TOTAL General Services**	638,094	349,304	291,462	1,278,860		1,278,860	38,967	1,317,827			8
	B. Health Care and Programs											
9	Medical Director			32,000	32,000		32,000		32,000			9
10	Nursing and Medical Records	3,141,138	167,875	79,249	3,388,262		3,388,262	61,701	3,449,963			10
10a	Therapy			673,387	673,387		673,387		673,387			10a
11	Activities	185,533	16,157	5,653	207,343		207,343		207,343			11
12	Social Services	47,535		5,767	53,302		53,302		53,302			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Allocated Benefits**							7,461	7,461			15
16	**TOTAL Health Care and Programs**	3,374,206	184,032	796,056	4,354,294		4,354,294	69,162	4,423,456			16
	C. General Administration											
17	Administrative	101,363		967,227	1,068,590		1,068,590	(863,378)	205,212			17
18	Directors Fees											18
19	Professional Services			78,221	78,221		78,221	3,426	81,647			19
20	Dues, Fees, Subscriptions & Promotions			34,973	34,973		34,973	958	35,931			20
21	Clerical & General Office Expenses	209,984	38,028	22,567	270,579		270,579	292,917	563,496			21
22	Employee Benefits & Payroll Taxes			603,365	603,365		603,365	12,849	616,214			22
23	Inservice Training & Education			1,561	1,561		1,561		1,561			23
24	Travel and Seminar			1,799	1,799		1,799	3,985	5,784			24
25	Other Admin. Staff Transportation			530	530		530	10,252	10,782			25
26	Insurance-Prop.Liab.Malpractice			170,664	170,664		170,664	4,564	175,228			26
27	Other (specify):* **Allocated Benefits**							45,009	45,009			27
28	**TOTAL General Administration**	311,347	38,028	1,880,907	2,230,282		2,230,282	(489,418)	1,740,864			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,323,647	571,364	2,968,425	7,863,436		7,863,436	(381,289)	7,482,147			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Wheeling #0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			30,258	30,258		30,258	237,187	267,445			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,543	29,543		29,543	336,410	365,953			32
33	Real Estate Taxes							437,688	437,688			33
34	Rent-Facility & Grounds			1,619,927	1,619,927		1,619,927	(1,618,455)	1,472			34
35	Rent-Equipment & Vehicles			5,092	5,092		5,092	3,104	8,196			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,684,820	1,684,820		1,684,820	(604,066)	1,080,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,004		148,004		148,004		148,004			39
40	Barber and Beauty Shops			23,467	23,467		23,467		23,467			40
41	Coffee and Gift Shops			1,294	1,294		1,294		1,294			41
42	Provider Participation Fee			121,330	121,330		121,330		121,330			42
43	Other (specify):* Nonallowable Costs			204,801	204,801		204,801	(204,801)				43
44	**TOTAL Special Cost Centers**		148,004	350,892	498,896		498,896	(204,801)	294,095			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,323,647	719,368	5,004,137	10,047,152		10,047,152	(1,190,156)	8,856,996			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(278)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,633)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,098)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,945)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(941)	43		13
14	Non-Care Related Interest	(26,600)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(179,499)	43		24
25	Fund Raising, Advertising and Promotional	(12,928)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(24,414)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (263,336)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(926,820)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (926,820)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,190,156)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/04-12/31/04

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Disallow nonallowable collection fees	(14,369)	19
Disallow out of period fees	(1,256)	19
Offset miscellaneous income	(57)	21
Nonallowable unclaimed property costs	(149)	21
Real estate tax refund costs	217	33
Nonallowable personal item replacement	(1,642)	43
Disallow radiology	(4,732)	43
Disallow laboratory	(2,426)	43
Total	(24,414)	

See Accountants' Compilation Report

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(278)	0	0	0	0	0	0	0	0	0	0	(278)	2
3	Housekeeping	0	0	320	0	0	0	0	0	0	0	0	320	3
4	Laundry	(4,098)	0	0	0	0	0	0	0	0	0	0	(4,098)	4
5	Heat and Other Utilities	0	0	3,654	0	0	0	0	0	0	0	0	3,654	5
6	Maintenance	0	0	46,936	0	0	0	0	0	0	0	0	46,936	6
7	Other (specify):*	0	0	5,282	0	0	0	0	0	0	0	0	5,282	7
8	**TOTAL General Services**	(4,376)	0	56,192	0	0	0	0	0	0	0	0	51,816	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	61,701	0	0	0	0	0	0	0	0	61,701	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	7,461	0	0	0	0	0	0	0	0	7,461	15
16	**TOTAL Health Care and Programs**	0	0	69,162	0	0	0	0	0	0	0	0	69,162	16
	C. General Administration													
17	Administrative	0	0	103,849	(967,227)	0	0	0	0	0	0	0	(863,378)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,052	18,915	0	0	0	0	0	0	0	0	34,967	19
20	Fees, Subscriptions & Promotions	0	0	958	0	0	0	0	0	0	0	0	958	20
21	Clerical & General Office Expenses	0	75	293,048	0	0	0	0	0	0	0	0	293,123	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,985	0	0	0	0	0	0	0	0	3,985	24
25	Other Admin. Staff Transportation	0	0	0	10,252	0	0	0	0	0	0	0	10,252	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	4,564	0	0	0	0	0	0	0	4,564	26
27	Other (specify):*	0	0	0	45,009	0	0	0	0	0	0	0	45,009	27
28	**TOTAL General Administration**	0	16,127	420,755	(907,402)	0	0	0	0	0	0	0	(470,520)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,376)	16,127	546,109	(907,402)	0	0	0	0	0	0	0	(349,542)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	206,203	0	30,984	0	0	0	0	0	0	0	237,187	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,545)	374,580	0	375	0	0	0	0	0	0	0	336,410	32
33	Real Estate Taxes	0	419,927	0	1,628	0	0	0	0	0	0	0	421,555	33
34	Rent-Facility & Grounds	0	(1,619,927)	0	1,472	0	0	0	0	0	0	0	(1,618,455)	34
35	Rent-Equipment & Vehicles	0	0	0	3,104	0	0	0	0	0	0	0	3,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,545)	(619,217)	0	37,563	0	0	0	0	0	0	0	(620,199)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(196,001)	0	0	0	0	0	0	0	0	0	0	(196,001)	43
44	**TOTAL Special Cost Centers**	(196,001)	0	0	0	0	0	0	0	0	0	0	(196,001)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(238,922)	(603,090)	546,109	(869,839)	0	0	0	0	0	0	0	(1,165,742)	45

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33%	See attached Schedule B		Lexington Health		
John Samatas Discretionary Trust	33.33%			Care Systems of		
Cynthia Thiem Discretionary Trust	33.34%			Wheeling Ltd. Ptsp.	Wheeling	Lessor
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	$ 16,052	$ 16,052	1
2	V	21	Bank charges		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75	2
3	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	206,203	206,203	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653	4
5	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	370,927	370,927	5
6	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	419,927	419,927	6
7	V	34	Rental expense	1,619,927	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,619,927)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V		**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.						13
14	Total			$ 1,619,927			$ 1,016,837	$ * (603,090)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/04-12/31/04

Schedule B

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 320	$ 320	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,474	3,474	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	92	92	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	88	88	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	43,679	43,679	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	3,257	3,257	20
21	V	7	Management allocation - employee benefits		Royal Management Corp.	**	5,282	5,282	21
22	V	10	Management allocation - salaries		Royal Management Corp.	**	61,701	61,701	22
23	V	15	Management allocation - employee benefits		Royal Management Corp.	**	7,461	7,461	23
24	V	17	Management allocation - salaries		Royal Management Corp.	**	103,849	103,849	24
25	V	19	Computer consultant & supplies		Royal Management Corp.	**	11,625	11,625	25
26	V	19	Professional fees		Royal Management Corp.	**	7,290	7,290	26
27	V	20	Dues & subscriptions		Royal Management Corp.	**	859	859	27
28	V	20	Licenses, permits & inspections		Royal Management Corp.	**	23	23	28
29	V	20	Advertising - help wanted		Royal Management Corp.	**	76	76	29
30	V	21	Management allocation - salaries		Royal Management Corp.	**	268,358	268,358	30
31	V	21	Bank charges		Royal Management Corp.	**	2,135	2,135	31
32	V	21	Office supplies & printing		Royal Management Corp.	**	9,069	9,069	32
33	V	21	Postage		Royal Management Corp.	**	3,715	3,715	33
34	V	21	Telephone		Royal Management Corp.	**	9,771	9,771	34
35	V	24	Travel & seminar		Royal Management Corp.	**	3,985	3,985	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. Own 100% of Royal Management Corp.						38
39	Total			$			$ 546,109	$ * 546,109	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 10,252	$ 10,252	15
16	V	26	Insurance general		Royal Management Corp.	**	4,564	4,564	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	45,009	45,009	17
18	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,325	3,325	18
19	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,209	7,209	19
20	V	30	Depreciation - equipment		Royal Management Corp.	**	20,450	20,450	20
21	V	32	Interest		Royal Management Corp.	**	375	375	21
22	V	33	Property taxes		Royal Management Corp.	**	1,628	1,628	22
23	V	34	Rent expense		Royal Management Corp.	**	1,472	1,472	23
24	V	35	Equipment rental		Royal Management Corp.	**	3,104	3,104	24
25	V	17	Management fees	967,227	Royal Management Corp.	**		(967,227)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Wheeling, Inc. Own 100% of Royal Management Corp.						38
39	Total			$ 967,227			$ 97,388	$ * (869,839)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	8%	Salary	$ 34,557	L17, C7	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule C	3	6%	Salary	24,684	L17, C7	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	3	6%	Salary	24,684	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	3%	Salary	6,012	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	10%	Salary	13,912	L17, C7	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,849		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923 **Schedule C**
1/1/04-12/31/04

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Total	202,159	283,023	202,159	49,242	113,933	850,516

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	$ 2,938	$	80,886	$ 320	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		80,886	3,474	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		80,886	92	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		80,886	88	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	80,886	43,679	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		80,886	3,257	6
7	7	Management allocation - employe	Bed Days	743,346	10	48,540		80,886	5,282	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	80,886	61,701	8
9	15	Management allocation - employe	Bed Days	743,346	10	68,569		80,886	7,461	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	80,886	103,849	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		80,886	11,625	11
12	19	Professional fees	Bed Days	743,346	10	66,993		80,886	7,290	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		80,886	859	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		80,886	23	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		80,886	76	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	80,886	268,358	16
17	21	Bank charges	Bed Days	743,346	10	19,618		80,886	2,135	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		80,886	9,069	18
19	21	Postage	Bed Days	743,346	10	34,142		80,886	3,715	19
20	21	Telephone	Bed Days	743,346	10	89,797		80,886	9,771	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		80,886	3,985	21
22										22
23										23
24										24
25	TOTALS					$ 5,018,749	$ 4,389,035		$ 546,109	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	$ 94,217	$	80,886	$ 10,252	1
2	26	Insurance general	Bed Days	743,346	10	41,943		80,886	4,564	2
3	27	Management allocation - employe	Bed Days	743,346	10	413,634		80,886	45,009	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557		80,886	3,325	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255		80,886	7,209	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937		80,886	20,450	6
7	32	Interest	Bed Days	743,346	10	3,446		80,886	375	7
8	33	Property taxes	Bed Days	743,346	10	14,963		80,886	1,628	8
9	34	Rent expense	Bed Days	743,346	10	13,526		80,886	1,472	9
10	35	Equipment rental	Bed Days	743,346	10	28,527		80,886	3,104	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 895,005	$		$ 97,388	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, L.L.C.	X		Mortgage	$49,514.00	12/29/98	6,513,000	5,392,184	12/29/08	0.0675	370,927	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	675,000	1,280,956	Demand	0.0425	26,600	6
7	LaSalle Bank, N.A.		X	Line of Credit	Various	12/01/02	1,000,000	275,000	05/31/05	Prime	2,943	7
8												8
9	TOTAL Facility Related				$49,514.00		$ 8,188,000	$ 6,948,140			$ 400,470	9
	B. Non-Facility Related*											
10								Amortization of loan costs			3,653	10
11								Interest income offset			(11,945)	11
12								Allocated from management company			375	12
13								Nonallowable shareholder interest			(26,600)	13
14	TOTAL Non-Facility Related						$	$			$ (34,517)	14
15	TOTALS (line 9+line14)						$ 8,188,000	$ 6,948,140			$ 365,953	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 432,000	1
	Allocated from Management Company	1,628	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 390,362	2
3. Under or (over) accrual (line 2 minus line 1).		$ (40,010)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 462,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 16,133	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 652 For 1997 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (435)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 437,688	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	373,589	8
	2000	379,331	9
	2001	379,253	10
	2002	410,289	11
	2003	390,362	12
2004 assessment:		2,146,438	
Equalization factor:		2.4598	
Tax rate:		0.08764	
Est. 04 taxes payable 05:		462,722	
Use:		462,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-10-401-027-0000	Land & Building	$ 390,362.00	$ 390,362.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 187,600.00	$ 1,628.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 577,962.00	$ 391,990.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	137,650	1993	$ 595,000	1
2	Mgmt Co.		2002	17,446	2
3	TOTALS	137,650		$ 612,446	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 6,537,447	$	10-40	$ 164,075	$ 164,075	$ 1,579,225	4
5	10		2000	2000	98,710	2,468	40	2,468		11,105	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvement			1995	3,587		15	239	239	2,302	9
10	Land improvement - sidewalk replacemen			1996	1,927	128	15	128		1,090	10
11	Leasehold improvement - pines & sod			1996	3,432	229	15	229		1,945	11
12	Basement rehab			1997	18,611	1,861	10	1,861		13,958	12
13	Building improvement - curtains/track			1997	1,936		35	55	55	414	13
14	Landscaping			1997	2,002	133	15	133		1,001	14
15	Wiring for MDS			1998	3,552	355	10	355		2,308	15
16	Parking Lot			1998	2,952	295	10	295		1,919	16
17	Roof repair			2000	1,980	198	10	198		891	17
18	Remodel HVAC/exhaust system - office area			2000	7,480	374	20	374		1,683	18
19	Automatic Door			2000	1,300	130	10	130		585	19
20	Rods for beside curtains			2000	2,525	253	10	253		1,137	20
21	Floor tile			2000	10,298	1,030	10	1,030		4,634	21
22	Parking lot seal coating and repair			2001	2,177	218	10	218		762	22
23	Infrared curtain units for 3 elevators			2001	4,500	900	5	900		3,150	23
24	Boiler vent repairs			2001	3,084	308	10	308		1,078	24
25	Kitchen wall rebuild			2003	22,500	1,125	20	1,125		1,500	25
26	Elevator upgrade			2004	11,077	369	20	369		369	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Land improvements - management company	2002	$ 27,497	$	15	$ 1,819	$ 1,819	$ 5,347	37
38	Building - management company	2002	213,924		40	5,227	5,227	15,599	38
39	HVAC, electrical, security system - management company	2003	2,120		30	146	146	201	39
40	Key card system - management company	2004	333		20	17	17	17	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,984,951	$ 10,374		$ 181,952	$ 171,578	$ 1,652,220	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 562,759	$ 27,825	$ 59,285	$ 31,460	3-10 yrs	$ 487,483	71
72	Current Year Purchases	67,347	2,433	2,433		5-10 yrs	2,433	72
73	Fully Depreciated Assets	35,254					35,254	73
74	Allocated from management company	205,197		20,450	20,450		85,702	74
75	TOTALS	$ 870,557	$ 30,258	$ 82,168	$ 51,910		$ 610,872	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from management company			42,943		3,325	3,325		29,507	79
80	TOTALS			$ 42,943	$	$ 3,325	$ 3,325		$ 29,507	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,510,897	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,632	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 267,445	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 226,813	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,292,599	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy rooms and reception	$	92
93	rehab	58,049	93
94			94
95		$ 58,049	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from management company				1,472			6
7	TOTAL				$ 1,472 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 8,196 Description: Copier $4,643 $; Fax machine $270; Postage meter $179; Allocated from management company - $3,104
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	3,732	$ 276,972	$	3,732	$ 276,972	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		854	51,472		854	51,472	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		6,965	343,384		6,965	343,384	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				148,004		148,004	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound therapy	L10A, C3				1,559			1,559	13
14	TOTAL			$	11,551	$ 673,387	$ 148,004	11,551	$ 821,391	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (3,990)	$ 2,895	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 727,000)	1,313,153	1,313,153	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,916	14,916	6
7	Other Prepaid Expenses	24,565	24,565	7
8	Accounts Receivable (owners or related parties)	3,730	3,730	8
9	Other(specify): Escrow		123,125	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,352,374	$ 1,482,384	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,698	8,698	12
13	Land		612,446	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	198,107	456,025	15
16	Equipment, at Historical Cost	247,097	913,500	16
17	Accumulated Depreciation (book methods)	(178,938)	(2,292,599)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	58,049	58,049	22
23	Other(specify): Unamortized mortgage costs		51,137	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 333,013	$ 6,336,182	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,685,387	$ 7,818,566	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 478,897	$ 478,897	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,555,956	1,555,956	29
30	Accrued Salaries Payable	308,238	308,238	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,999	5,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)		462,000	32
33	Accrued Interest Payable		30,331	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	1,741,191	130,860	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,090,281	$ 2,972,281	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,392,184	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,392,184	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,090,281	$ 8,364,465	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,404,894)	$ (545,899)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,685,387	$ 7,818,566	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/04-12/31/04

Schedule E

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	1,610,331	
Accrued management fees	77,844	77,844
Accrued 401 (k) contribution	12,335	12,335
Other accrued expenses	40,681	40,681
Total line 36	1,741,191	130,860

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	57
Investment in Lexington Financial Services II, LLC.	86
Vending Machine Commissions	682
Total line 28	825

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (678,570)	1
2	Restatements (describe):		2
3	**Post closing adjustments**	(192,027)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (870,597)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,534,297)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,534,297)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,404,894)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,475,925	1
2	Discounts and Allowances for all Levels	(471,471)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,004,454	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,090,393	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,090,393	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,684	12
13	Barber and Beauty Care	26,782	13
14	Non-Patient Meals	278	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	293,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,558	19
20	Radiology and X-Ray	6,055	20
21	Other Medical Services	57,232	21
22	Laundry	4,098	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 405,238	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,945	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,945	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	825	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 825	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,512,855	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,278,860	31
32	Health Care	4,354,294	32
33	General Administration	2,230,282	33
	B. Capital Expense		
34	Ownership	1,684,820	34
	C. Ancillary Expense		
35	Special Cost Centers	377,566	35
36	Provider Participation Fee	121,330	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,047,152	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,534,297)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,534,297)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,991	2,161	$ 92,704	$ 42.90	1
2	Assistant Director of Nursing	4,057	4,430	138,828	31.34	2
3	Registered Nurses	43,453	46,881	1,411,476	30.11	3
4	Licensed Practical Nurses	6,649	7,378	175,399	23.77	4
5	Nurse Aides & Orderlies	93,261	99,329	1,234,695	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,623	7,179	88,036	12.26	8
9	Activity Director	1,849	1,956	30,093	15.38	9
10	Activity Assistants	15,055	16,069	155,440	9.67	10
11	Social Service Workers	2,437	2,652	47,535	17.92	11
12	Dietician	1,862	2,024	28,469	14.07	12
13	Food Service Supervisor	1,903	2,031	29,139	14.35	13
14	Head Cook	2,008	2,169	22,299	10.28	14
15	Cook Helpers/Assistants	12,113	12,829	97,991	7.64	15
16	Dishwashers	17,073	17,778	110,662	6.22	16
17	Maintenance Workers	2,073	2,186	31,263	14.30	17
18	Housekeepers	35,856	38,227	256,377	6.71	18
19	Laundry	8,956	9,499	61,894	6.52	19
20	Administrator	2,202	2,295	101,363	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,947	14,784	209,984	14.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,368	291,857	$ 4,323,647 *	$ 14.81	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	324	$ 14,502	L1, C3	35
36	Medical Director	Monthly	32,000	L9, C3	36
37	Medical Records Consultant	19	1,070	L10, C3	37
38	Nurse Consultant	115	7,461	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	119	5,653	L11, C3	44
45	Social Service Consultant	128	5,767	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	705	$ 67,653		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,060	$ 21,198	L10, C3	50
51	Licensed Practical Nurses	231	4,159	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,291	$ 25,357		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Curtis	Administrator	0%	$ 20,406
Pam Harshbarger	Administrator	0%	27,957
Esther Davis	Administrator	0%	8,638
Katherine Dyhouse	Administrator	0%	22,238
Sandra Cashman	Administrator	0%	22,124
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,363

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 967,227
TOTAL (agree to Schedule V, line 17, col. 3)	$ 967,227
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting	$ 15,271
American Express Tax & Bus. Svs.	Accounting	17,005
Avail Corporation	Accounting	248
Cassiday Schlade & Gloor	Legal	1,518
Katten, Muchin, Zavis & Rosenman	Legal	1,250
Scott & Krause	Bond Consulting	1,201
James Samatas	Legal	100
Personnel Planners	U/C Consulting	870
Sachnoff and Weaver	Legal	13,682
Grabowski & Green	Collections	14,369
See attached Schedule F		12,707
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 78,221

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,079
Unemployment Compensation Insurance	54,003
FICA Taxes	309,775
Employee Health Insurance	132,996
Employee Meals	12,849
Illinois Municipal Retirement Fund (IMRF)*	
401(k) contribution	12,930
Life insurance	4,477
Other employee benefits	17,105
TOTAL (agree to Schedule V, line 22, col.8)	$ 616,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,420
Advertising: Employee Recruitment	27,456
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Dues & Subs	128
Miscellaneous Licenses & Permits	969
Allocated from management company	958
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,931

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,799
Allocated from management company	3,985
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,784

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/04-12/31/04

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee		Type	Amount
	Carilyn Jeschke	Staffing consultant	2,287
	Telenet Communications	Computer consulting	205
	Advanced Answers on Demand, Inc.	Computer consulting	2,652
	Information Control, Inc.	Computer consulting	1,156
	Gigatrend	Computer consulting	195
	Lanac	Computer consulting	792
	AdminaStar	Computer consulting	396
	National Datacare Corporation	Computer consulting	1,139
	McLeod USA	Computer consulting	285
	eHealth Solutions	Computer consulting	3,600
			12,707
Total, Agrees to Schedule V, Line 19, Column 3			78,221
Allocated from management co.			
	American Express Tax & Business Services	Accounting	330
	Altschuler, Melvoin and Glasser LLP	Accounting	527
	Account Temps	Accounting	900
	Avail Corporation	Accounting	25
	Doris Fischer	Medicaid Billing Consultant	2,317
	Gene Whitehorn	Medicaid Billing Consultant	800
	Susan Parker, LCSW	DNR Consulting	12
	Personnel Planners	U/C Consulting	13
	Gilson, Labus and Silverman	Accounting	273
	James Samatas	Legal	39
	Sachnoff and Weaver	Legal	1,080
	ING / Pension Administrators	401 (k) Administration	946
	Eric Haider	Consulting	28
	Various	Computer Consulting	11,625
Allocated from building partnership			
	James Samatas	Filing and recording fees	136
	McCracken, Walsh, de Lavan	Real estate tax appeal fees	7,346
	Dennis W. Hetler & Associates	Real estate tax appeal fees	4,070
	JSO Valuation Group, LTD.	Real estate appraisal fees	4,500
Reclassifications			
	McCracken, Walsh, de Lavan	Real estate tax appeal fees	(7,346)
	Dennis W. Hetler & Associates	Real estate tax appeal fees	(4,070)
	JSO Valuation Group, LTD.	Real estate appraisal fees	(4,500)
Nonallowable legal fees			
	Sachnoff and Weaver	Legal-collection fees	(13)
	Scott & Krause	Bond Consulting - out of period	(228)
	Grabowski & Green	Collection fees	(14,369)
	Katten, Muchin, Zavis and Rosenman	Legal-out of period fees	(1,015)
Total, Agrees to Schedule V, Line 19, Column 8			81,647

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$ N/A	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,933** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **121,330**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,849** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **278**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	288,560	28,128	14,502	331,190	0	331,190	0	331,190
2. Food Purchase	0	271,324	0	271,324	0	271,324	-13,127	258,197
3. Housekeeping	256,377	29,244	0	285,621	0	285,621	320	285,941
4. Laundry	61,894	20,608	0	82,502	0	82,502	-4,098	78,404
5. Heat and Other Utilities	0	0	170,942	170,942	0	170,942	3,654	174,596
6. Maintenance	31,263	0	106,018	137,281	0	137,281	46,936	184,217
7. Other (specify)*	0	0	0	0	0	0	5,282	5,282
8. Total General Services	638,094	349,304	291,462	1,278,860	0	1,278,860	38,967	1,317,827
9. Medical Director	0	0	32,000	32,000	0	32,000	0	32,000
10. Nursing & Medical Records	3,141,138	167,875	79,249	3,388,262	0	3,388,262	61,701	3,449,963
10a. Therapy	0	0	673,387	673,387	0	673,387	0	673,387
11. Activities	185,533	16,157	5,653	207,343	0	207,343	0	207,343
12. Social Services	47,535	0	5,767	53,302	0	53,302	0	53,302
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,461	7,461
16. Total Health Care & Programs	3,374,206	184,032	796,056	4,354,294	0	4,354,294	69,162	4,423,456
17. Administrative	101,363	0	967,227	1,068,590	0	1,068,590	-863,378	205,212
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	78,221	78,221	0	78,221	3,426	81,647
20. Fees, Subscriptions & Promotion	0	0	34,973	34,973	0	34,973	958	35,931
21. Clerical & General Office	209,984	38,028	22,567	270,579	0	270,579	292,917	563,496
22. Employee Benefits & Payroll	0	0	603,365	603,365	0	603,365	12,849	616,214
23. Inservice Training & Education	0	0	1,561	1,561	0	1,561	0	1,561
24. Travel and Seminar	0	0	1,799	1,799	0	1,799	3,985	5,784
25. Other Admin. Staff Trans	0	0	530	530	0	530	10,252	10,782
26. Insurance-Prop.Liab.Malpractice	0	0	170,664	170,664	0	170,664	4,564	175,228
27. Other (specify)*	0	0	0	0	0	0	45,009	45,009
28. Total General Adminis	311,347	38,028	1,880,907	2,230,282	0	2,230,282	-489,418	1,740,864
29. Total General Administrative	4,323,647	571,364	2,968,425	7,863,436	0	7,863,436	-381,289	7,482,147
30. Depreciation	0	0	30,258	30,258	0	30,258	237,187	267,445
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	29,543	29,543	0	29,543	336,410	365,953
33. Real Estate	0	0	0	0	0	0	437,688	437,688
34. Rent - Facility & Grounds	0	0	1,619,927	1,619,927	0	1,619,927	-1,618,455	1,472
35. Rent - Equipment & Vehicles	0	0	5,092	5,092	0	5,092	3,104	8,196
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,684,820	1,684,820	0	1,684,820	-604,066	1,080,754
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	148,004	0	148,004	0	148,004	0	148,004
40. Barber and Beauty Shop	0	0	23,467	23,467	0	23,467	0	23,467
41. Coffee and Gift Shops	0	0	1,294	1,294	0	1,294	0	1,294
42. Provider Participation	0	0	121,330	121,330	0	121,330	0	121,330
43. Other (specify):*	0	0	204,801	204,801	0	204,801	-204,801	0
44. Total Special Cost Ce	0	148,004	350,892	498,896	0	498,896	-204,801	294,095
45. Grand Total	4,323,647	719,368	5,004,137	10,047,152	0	10,047,152	-1,190,156	8,856,996

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-3,990	2,895
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,313,153	1,313,153
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	14,916	14,916
7. Other Prepaid Expenses	24,565	24,565
8. Accounts Receivable-Owner/Related Party	3,730	3,730
9. Other (specify):	0	123,125
10. Total current assets	1,352,374	1,482,384
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	8,698	8,698
13. Land	0	612,446
14. Buildings, at Historical Cost	0	6,528,926
15. Leasehold Improvements, Historical Cost	198,107	456,025
16. Equipment, at Historical Cost	247,097	913,500
17. Accumulated Depreciation (book methods)	-178,938	-2,292,599
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	58,049	58,049
23. other (specify):	0	51,137
24. Total Long-Term Assets	333,013	6,336,182
25. Total Assets	1,685,387	7,818,566
CURRENT LIABILITIES		
26. Accounts Payable	478,897	478,897
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,555,956	1,555,956
30. Accrued Salaries Payable	308,238	308,238
31. Accrued Taxes Payable	5,999	5,999
32. Accrued Real Estate Taxes	0	462,000
33. Accrued Interest Payable	0	30,331
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,741,191	130,860
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	4,090,281	2,972,281
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	5,392,184
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,392,184
46.Total Liabilities	4,090,281	8,364,465
47.Total Equity	-2,404,894	-545,899
48.Total Liabilities and Equity	1,685,387	7,818,566

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,475,925
2. Discounts and Allowances for all Levels	-471,471
Subtotal - Inpatient Care	7,004,454
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,090,393
7. Oxygen	0
Subtotal - Anciliary Revenue	1,090,393
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	1,684
13. Barber and Beauty Care	26,782
14. Non-Patient Meals	278
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	293,551
18. Sale of Supplies to Non-Patients	0
19. Laboratory	15,558
20. Radiologyand X-Ray	6,055
21. Other Medical Services	57,232
22. Laundry	4,098
Subtotal - Other Operating Revenue	405,238
24. Contributions	0
25. Interest and Other Investments Income	11,945
Subtotal - Non-Operating Revenue	11,945
27. Other Revenue (specify):	0
28. Other Revenue (specify):	825
Subtotal - Other Revenue	825
30. Total Revenue	8,512,855
31. General Services	1,278,860
32. Health Care	4,354,294
33. General Administration	2,230,282
34. Ownership	1,684,820
35. Special Cost Centers	377,566
35. Provider Participation Fee	121,330
37. Other	0
40. Total Expenses	10,047,152
41. Income Before Income Taxes	-1,534,297
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,534,297
43. Net Income or Loss for the Year	-1,488,323

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